

FILED MAR 20 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

8978

1000

BIRTH NO.		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No.	
1. PLACE OF DEATH a. COUNTY <u>JACKSON</u> b. CITY (If outside corporate limits, write RURAL and give town) <u>KANSAS CITY</u> c. LENGTH OF STAY (in this place) <u>24 YEARS</u> d. FULL NAME OF HOSPITAL OR INSTITUTION <u>ST. JOSEPH HOSPITAL</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>JACKSON</u> c. CITY (If outside corporate limits, write RURAL and give township) <u>KANSAS CITY</u> d. STREET ADDRESS (If rural, give location) <u>520 SOUTH LAWN AVENUE</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>EMMA</u> b. (Middle) <u>E.</u> c. (Last) <u>SADER</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>MAR-1-1950</u>		5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>		8. DATE OF BIRTH <u>DEC-2-1872</u>		9. AGE (In years last birthday) <u>77 YEARS</u>		10. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
11. BIRTHPLACE (State or foreign country) <u>4 SWEDEN</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>UNKNOWN</u>		13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
14. NAME OF HUSBAND OR WIFE <u>WILLIAM A. SADER</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Marie Wachtler</u> ADDRESS <u>520 S. LAWN AVE. KANSAS CITY, MO.</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral embolism</u> ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>Fractured left Hip</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Fractured left Hip</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>12 days</u>			
19a. DATE OF OPERATION <u>2/22/50</u>		19b. MAJOR FINDINGS OF OPERATION <u>Application of Bone Anderson Splint</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21. DATE SIGNED <u>3-1-50</u>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>Accident</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>		21c. (CITY, TOWN, OR TOWNSHIP) <u>Kansas City</u> (COUNTY) <u>Jackson</u> (STATE) <u>MO</u>		21d. HOW DID INJURY OCCUR? <u>Fell on floor</u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>2 19 50 10A</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22. I hereby certify that I attended the deceased from <u>2-15</u> , 19 <u>50</u> , to <u>3-1</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>3-1</u> , 19 <u>50</u> , and that death occurred at <u>9 20 A</u> , from the causes and on the date stated above.		23a. SIGNATURE <u>John T. Skinner</u> (Degree or title) <u>MD</u>	
23b. ADDRESS <u>1102 Grand K. C. MO</u>		23c. DATE SIGNED <u>3-1-50</u>		24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>MAR 3-1950</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>FOREST HILL CEMETERY</u>		24d. LOCATION (City, town, or county) <u>KANSAS CITY</u> (State) <u>MISSOURI</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>D. A. Newcomer's Sons</u> ADDRESS <u>139 E. BAYVIEW CREEK KANSAS CITY, MO.</u>		26. DATE REC'D BY LOCAL REG. <u>3-3-50</u>	
26. REGISTRAR'S SIGNATURE <u>Geraldine Holmes</u>		26. REGISTRAR'S SIGNATURE <u>Geraldine Holmes</u>		26. REGISTRAR'S SIGNATURE <u>Geraldine Holmes</u>		26. REGISTRAR'S SIGNATURE <u>Geraldine Holmes</u>	

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

627

Newcomb

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

_____, Student Embalmer No. _____,
working under my personal supervision.

Student
Student Embalmer

Signed

Licensed Embalmer No.

P. O. Address

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.